## Schedule 13
## Change Request for FY 08-09 Budget Request Cycle

| | | | | |
|---|---|---|---|---|
| | **Decision Item FY 08-09** ☑ | **Base Reduction Item FY 08-09** ☐ | **Supplemental FY 07-08** ☐ | **Budget Request Amendment FY 08-09** ☐ |
| **Request Title:** | Provider Rate Increases | | | |
| **Department:** | Health Care Policy and Financing | **Dept. Approval by:** | John Bartholomew BB | **Date:** November 1, 2007 |
| **Priority Number:** | DI-6 | **OSPB Approval:** | | **Date:** 10/23/07 for 11/1/07 |

| | Fund | 1 Prior-Year Actual FY 06-07 | 2 Appropriation FY 07-08 | 3 Supplemental Request FY 07-08 | 4 Total Revised Request FY 07-08 | 5 Base Request FY 08-09 | 6 Decision/ Base Reduction FY 08-09 | 7 November 1 Request FY 08-09 | 8 Budget Amendment FY 08-09 | 9 Total Revised Request FY 08-09 | 10 Change from Base (Column 5) FY 09-10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total of All Line Items** | **Total** | 2,061,396,808 | 2,147,858,908 | 0 | 2,147,858,908 | 2,147,626,990 | 17,091,875 | 2,164,718,865 | 0 | 2,164,718,865 | 17,091,875 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 633,377,714 | 652,421,500 | 0 | 652,421,500 | 651,512,742 | 8,264,081 | 659,776,823 | 0 | 659,776,823 | 8,264,081 |
| | **GFE** | 343,100,000 | 343,900,000 | 0 | 343,900,000 | 343,900,000 | 0 | 343,900,000 | 0 | 343,900,000 | 0 |
| | **CF** | 0 | 38,256 | 0 | 38,256 | 38,256 | 0 | 38,256 | 0 | 38,256 | 0 |
| | **CFE** | 48,860,206 | 76,001,368 | 0 | 76,001,368 | 76,794,167 | 281,858 | 77,076,025 | 0 | 77,076,025 | 281,858 |
| | **FF** | 1,036,058,888 | 1,075,497,784 | 0 | 1,075,497,784 | 1,075,381,825 | 8,545,936 | 1,083,927,761 | 0 | 1,083,927,761 | 8,545,936 |
| **(2) Medical Services Premiums** | **Total** | 2,061,396,808 | 2,147,858,908 | 0 | 2,147,858,908 | 2,147,626,990 | 17,091,875 | 2,164,718,865 | 0 | 2,164,718,865 | 17,091,875 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 633,377,714 | 652,421,500 | 0 | 652,421,500 | 651,512,742 | 8,264,081 | 659,776,823 | 0 | 659,776,823 | 8,264,081 |
| | **GFE** | 343,100,000 | 343,900,000 | 0 | 343,900,000 | 343,900,000 | 0 | 343,900,000 | 0 | 343,900,000 | 0 |
| | **CF** | 0 | 38,256 | 0 | 38,256 | 38,256 | 0 | 38,256 | 0 | 38,256 | 0 |
| | **CFE** | 48,860,206 | 76,001,368 | 0 | 76,001,368 | 76,794,167 | 281,858 | 77,076,025 | 0 | 77,076,025 | 281,858 |
| | **FF** | 1,036,058,888 | 1,075,497,784 | 0 | 1,075,497,784 | 1,075,381,825 | 8,545,936 | 1,083,927,761 | 0 | 1,083,927,761 | 8,545,936 |

**Letternote revised text:**

**Cash Fund name/number, Federal Fund Grant name:** CFE: Health Care Expansion Fund; FF: Title XIX

**IT Request:** ☐ **Yes** ☑ **No**

**Request Affects Other Departments:** ☐ **Yes** ☑ **No** **If Yes, List Other Departments Here:**

# CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

| | |
|---|---|
| Department: | Health Care Policy and Financing |
| Priority Number: | DI-6 |
| Change Request Title: | Provider Rate Increases |

**SELECT ONE (click on box):**

☒ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☐ Supplemental Request FY 07-08
☐ Budget Request Amendment FY 08-09

**SELECT ONE (click on box):**

Supplemental or Budget Request Amendment Criterion:
☒ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: This Change Request increases funding for the Department's Medical Services Premiums Long Bill group by $17,091,875 in FY 08-09 in order to: increase inpatient hospital rates; increase rates paid for preventive medicine; develop a medical home pilot program; increase rates paid for substance abuse treatment; increase rates paid for vision benefits; increase rates paid for dental benefits; increase rates paid for radiology services; and, increase rates paid for the Prenatal Plus program.

Background and Appropriation History: Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, disabled, adults, and children. The Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX. As part of its annual Budget Request, the Department includes a Decision Item (DI-1) for caseload and utilization increases in its line item for Title XIX services, Medical Services Premiums. The Department's Request for Medical Services Premiums, however, does not include any rate increases to providers

who participate in the Medicaid program; the requested increases only account for additional clients and changes in utilization patterns.[1]

As such, providers in Medicaid who are paid based on the fee-schedule maintained by the Department do not receive any increase in rates in the Department's annual request for Medical Services Premiums. Beginning in FY 05-06, the General Assembly has appropriated funds to provide rate increases to some Medicaid providers. In SB 05-209, the General Assembly appropriated $18,866,498 for rate increases to Medicaid providers for FY 05-06 in the following way:

- In SB 05-209, the General Assembly appropriated $7,365,778 for a 2% increase to inpatient hospital services provided to Medicaid clients. The Department applied the 2% rate increase to every hospital's inpatient rate, effective July 1, 2005 (Footnote 37).
- In SB 05-209, the General Assembly appropriated $6,831,445 with the intent of "[increasing] reimbursement rates for the top five physician procedure codes up to eighty percent of the Medicare rate" (SB 05-209, Footnote 39). With the available funds, the Department was able to increase reimbursement for the top nine office-based evaluation and management procedure codes to 80% of the Medicare rate effective July 1, 2005 (Footnote 39).
- In SB 05-209, the General Assembly appropriated $4,669,275 for a 2% rate increase for home and community-based waiver services, private duty nursing services, and home health services. The Department applied the rate increase to those services effective July 1, 2005 (Footnote 40).

During FY 05-06, the General Assembly approved a Supplemental bill, HB 06-1369, for the Department, which also contained rate increases for Medicaid providers. HB 06-1369 provided rate increases in the following way:

[1] Some providers, such as outpatient hospitals, pharmacies, federally qualified health care centers, and nursing facilities are paid based on incurred costs, or via cost-based rates, most as required by federal regulation or state statute. Such providers are not included in this Change Request.

- In HB 06-1369, the General Assembly appropriated $831,000 for a 1% rate increase for inpatient hospital services. HB 06-1385 included $3,604,228 to annualize the rate increase in FY 06-07 (Figure Setting, March 13, 2006, page 146).[2] The Department implemented the rate increase by increasing each hospital's inpatient rate by 1%, effective April 1, 2006 (Footnote 37a).
- In HB 06-1369, the General Assembly appropriated $5,100,000 for rate increases to long-term care community providers. HB 06-1385 included $20,812,658 to annualize the rate increase in FY 06-07 (Figure Setting, March 13, 2006, page 146).[3] The Department increased rates to long-term care community providers effective April 1, 2006 in the following way: assisted living facilities, 15.07%; day care services, 3.57%; skilled nursing, 7.20%; home health aides, 4.20%; physical therapy, 36.30%; speech therapy, 35.90%; occupational therapy, 29.20%; private duty registered nursing, 3.80%; private duty licensed nursing, 8.00%; personal care homemaker, 10.00%; and, all other providers, 2.57% (Footnote 40a).
- In HB 06-1369, the General Assembly appropriated $309,000 for a 2% rate increase for durable medical equipment rates. HB 06-1385 included $1,311,382 to annualize the rate increase in FY 06-07 (Figure Setting, March 13, 2006, page 146).[4] The Department implemented the rate increase by increasing all Medicaid fee-for-service durable medical equipment billing codes 2.25% and excluding durable medical equipment services that are paid by invoice plus 19%, effective April 1, 2006 (Footnote 42a).

In HB 06-1385, the General Assembly approved rate increases for FY 06-07 in the following way:

- In HB 06-1385, the General Assembly appropriated $9,917,925 for a 3.25% rate increase for primary care providers, including: physician; dental; Early Periodic

[2] The Figure Setting document does not reflect the final action by the Joint Budget Committee. The annualization amount was adjusted based on Joint Budget Committee motions, and the final annualization total is reflected in a Joint Budget Committee staff memorandum on March 16, 2006.
[3] See footnote 2.
[4] See footnote 2.

Screening, Diagnosis, and Treatment; lab and x-ray; and, durable medical equipment. In response, starting with the total funds available, the Department determined the dollar amount available if the 3.25% were applied to all applicable physician codes. This amount ($6,861,522) was then applied to the top twenty-five most frequently billed Evaluation and Management (E&M) physician services codes. These E&M codes correspond to the most common primary care physician services provided. The remaining allocated funds ($3,056,403) were used to apply a 3.25% to all Medicaid fee-for-service dental and Durable Medical Equipment (DME) codes. DME services that are paid by-invoice plus 19% were restored to plus 20% which was the by-invoice payment methodology prior to rate decreases that went into effect in 2004. These rate increases were effective July 1, 2006 (Footnote 26)

- In HB 06-1385, the General Assembly appropriated $11,713,742 for a 3.25% rate increase for inpatient hospital services provided to Medicaid clients, beginning July 1, 2006. The Department implemented the rate increase by increasing inpatient hospital rates 3.25%, effective July 1, 2006 (Footnote 27).
- In HB 06-1385, the General Assembly appropriated $4,138,750 for rate increases to long-term care community providers, effective April 1, 2007, in the following way: assisted living facilities, 12.50%; day care services, 1.00%; skilled nursing, 23.60%; physical therapy, 23.60%; speech therapy 23.60%; occupational therapy, 23.60%; private duty registered nursing, 23.40%; and, private duty licensed nursing, 23.60%. The Department intends to implement the rate increases on April 1, 2007 (Footnote 28).

In SB 07-239, the General Assembly approved rate increases for FY 07-08 in the following way:

- In SB 07-239, the General Assembly appropriated $5,081,736 for a 1.5% rate increase for home and community-based long-term care providers, home health, and private duty nursing providers, beginning July 1, 2007. The Department implemented the rate increase by increasing rates for the specified providers by 1.5%, effective July 1, 2007 (Footnote 28).

- In SB 07-239, the General Assembly appropriated $4,446,001 for a 1.5% rate increase for inpatient hospital services provided to Medicaid clients, beginning July 1, 2007. The Department implemented the rate increase by increasing inpatient hospital rates 1.5%, effective July 1, 2007 (Footnote 29).
- In SB 07-239, the General Assembly appropriated $11,541,853 for rate increases targeted to specific providers and services, effective July 1, 2007. The rate increases included the following providers and services: Emergency Transportation, adult immunizations, anesthesia, wheelchair repair, intrauterine devices, surgical procedures, outpatient therapy services, and single entry point contracts. The Department implemented the rate increase by increasing rates for the specified providers and services effective July 1, 2007 (Footnote 29).

To date, the rate increases appropriated by the General Assembly have targeted programs with high utilization that comprise a large part of Medicaid expenditure, providers affected by rate cuts, and services where the cost of providing the service exceeded the Medicaid reimbursement rate. These rate increases have helped to offset the effects of rate cuts during FY 02-03, FY 03-04, and FY 04-05.

In HB 06-1385 (Footnote 22) and SB 07-239 (Footnote 24), the Department was appropriated funding for a Primary Care Provider Rate Task Force and Study. Although the results of that study are not directly discussed in this Change Request, the Department's recommendations with respect to preventive medicine and medical homes reflect the conclusions of the Task Force.

General Description of Request:

For FY 08-09, the Department is targeting seven service areas for rate increases: inpatient hospitals; preventive medicine and medical homes; substance abuse; vision benefits; dental services; and, radiology services.

**Inpatient Hospital**

Under State budgeting principles, inpatient hospital rates are currently required to remain budget neutral to FY 02-03 rates, only allowing for an increase in utilization, unless a Change Request is approved. This is supported in the Department's Medicaid State Plan. The methodology used to calculate the Medicaid inpatient hospital base rates does not apply any inflationary increase, such as Medicare's hospital market basket index, without a budget action. Historically, the Department has used Medicare hospital rates as a benchmark for comparison. For FY 03-04, the first year that Medicaid rates were based on Medicare's rates, Medicaid rates were set at 97.9% of Medicare's rates in order to be budget neutral to FY 02-03 expenditures. In FY 04-05, Medicaid rates fell to 92.6% of Medicare's rates; in FY 05-06 Medicaid rates were set at 90% of Medicare's rates; and, in FY 06-07, Medicaid rates were set at 92% of Medicare's rates, including the rate increases provided in HB 06-1369 and HB 06-1385. In FY 07-08, Medicaid rates were approximately equal to 91.3% of Medicare's rates, including the rate increase provided in SB 07-239. Total reimbursement for inpatient hospitals in FY 06-07 (not including upper payment limit financing) was $304,687,402 (Exhibits for Medical Services Premiums, Exhibit N, page 1).

In the August 3, 2007 Federal Register (Vol. 72, No. 149), the Centers for Medicare and Medicaid Services (CMS) published significant changes to the Medicare hospital inpatient prospective payment system. Under the new methodology, the current diagnostic related grouper (DRG) classification system will be replaced with a new DRG system which better recognizes the severity of the condition being treated. Because the Department's payment methodology is based primarily on the Medicare methodology in place during federal fiscal year 2007, it is no longer useful to compare rates on a hospital-by-hospital basis between Medicare and Medicaid because of the different system of measurement. The new Medicare rates are effective as of October 1, 2007.

For FY 08-09, the Department recommends applying a 1.5% rate increase to all inpatient hospital rates. This rate increase would be applied after all budget neutrality provisions are applied, in a manner consistent with the way the Department has apportioned rate increases appropriated by the General Assembly in FY 05-06, FY 06-07, and FY 07-08.

In order to raise inpatient hospital rates by 1.5%, the Department recommends an appropriation of $4,679,688.

**Preventive Medicine and Medical Homes**

In HB 06-1385 (Footnote 22) and SB 07-239 (Footnote 24), the Department was appropriated funding for a Primary Care Provider Rate Task Force and Study. Although the results of that study are not directly discussed in this Change Request, the Department's recommendations with respect to preventive medicine and medical homes reflect the conclusions of the Task Force. Additionally, due to funding constraints, the Department's recommendations do not seek to fully implement the recommendations of the Task Force at this time; rather, the Department anticipates that full implementation of the recommendations will be a multi-year process.

*Evaluation and Management*

In FY 05-06 and FY 06-07, the Department used limited funding to apply rate increases to the most frequently used Evaluation and Management (E&M) procedure codes. Specific services include examinations, evaluations, treatments, preventive pediatric and adult health supervision, and similar medical services. Due to budgetary restraints, the Department was only able to target the most frequently utilized codes.

In response, the Department recommends raising the rates of 12 specific preventive medicine evaluation and management codes to 90% of the Medicare rate. The codes targeted by the Department are for "periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures."[5]

The Department calculates that an appropriation of $1,514,747 would be sufficient to raise the rates to this level. These codes are for age specific new and established patients

[5] The Department intends to target Current Procedural Terminology (CPT) codes 99381 through 99387 and 99391 through 99397. The included description of these codes was obtained from the American Medical Association's website, at http://www.ama-assn.org/.

that are currently priced between 36.5% and 58.5% of the equivalent Medicare rate. Additionally, these codes have not been included in any prior year rate increases.

Furthermore, the Department recommends an additional appropriation of $1,750,000 to increase rates on frequently used evaluation and management codes which have been included in any of the recent provider rate increases. There are over 75 additional evaluation and management codes which have not received any rate adjustment during recent rate increases. The Department aims to increase all evaluation and management codes to 90% of the equivalent Medicare rate; however, at the same time, the Department recognizes the fiscal constraints under which it operates. Therefore, the Department intends to use this funding to increase these codes to approximately 83.4% of the Medicare rates at this time, which is on approximately a 17.65% rate increase for each code on average.

*Medical Homes*

During the 2007 legislative session, the General Assembly passed SB 07-130, which requires the Department to develop systems and standards to maximize the number of children enrolled in the Medicaid program who have a Medical Home. A Medical Home is defined in part as "an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child" at 25.5-1-103 (5.5), C.R.S. (2007).

SB 07-130 did not contain any appropriation for the purpose of raising provider rates associated with Medical Home services. During meetings associated with the Primary Care Provider Rate Task Force (as required by Footnote 22 of HB 06-1385), the Department learned that provider rates for Medical Home related services were not adequate enough to ensure provider participation. Therefore, as part of the Department's effort to maximize the number of participating providers and the number of children enrolled, the Department seeks to initiate a pay-for-performance pilot program to evaluate

the effectiveness and cost savings for a select number of clients in an identified Medical Home. The pilot program will involve 124 providers, serving approximately 10,000 children.

The Department recommends an appropriation of $222,255 for the Medical Home pilot program. Reimbursement rates for children ages 0-4 will be increased by $10.00 for the annual well child visit. Reimbursement rates for children ages 5-20 will be increased by $40.00 for an annual well child visit. Any savings identified from the program will be incorporated in the Department's annual Budget Request for Medical Services Premiums.

**Substance Abuse**

During the 2005 legislative session, the General Assembly passed HB 05-1015, which created an outpatient substance abuse in the Medical Assistance Program. As detailed in the Legislative Council fiscal note of April 20, 2005, initial estimates of client participation were high. Initial rates were based on the Department of Human Services' Special Connections program, although rates in that program had not been increased since the program's inception in 1992. Providers have indicated that rates are set too low to encourage and promote utilization of the benefit.

The Department seeks to adjust rates in line with average commercial reimbursement. To that end, the Department intends to increase the hourly reimbursement rates for group sessions at an average of 23% and hourly reimbursement rates for individual sessions at an average of 63%. The Department assumes that Medicaid utilization of the Special Connections benefit will increase by approximately 50%, while utilization in the Department's own outpatient substance abuse will increase by approximately 375%. Therefore, the Department recommends an appropriation of $750,000, which includes both the cost of the rate increases and the utilization growth expected as a result of additional providers willing to participate in the program.

**Vision Benefits**

Currently, the Department provides an eyeglass benefit (frames and lenses) for children 20 and under when medically necessary and for adult clients following eye surgery. The majority of rates for eyeglass benefits were set in 1987. During FY 02-03 rates were cut by 5.00%, and in FY 04-05, rates were cut by an additional 1.00%. Some of the impact of the rate cuts was mitigated by a 3.25% increase in FY 06-07. However, because rates have not been rebased since 1987, Medicaid reimbursement is currently well below reimbursement rates paid by commercial insurers and providers' reported costs.

The Department recommends an appropriation of $500,000 to increase the payment rates for the most frequently used procedure codes for frames and lenses. This would increase reimbursement rates for these services by 33.45% on average.

**Dental Services**

Comprehensive dental services are a Colorado Medical Assistance Program benefit under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for clients from birth through the age of 20. The Department is required by Federal law to provide "[d]ental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health" (42 CFR § 441.56 (c) (2) [2006]). Only limited medically necessary dental benefits are available for adults, age 21 and older, and for non-citizens. Colorado Medical Assistance Program dental benefits for adults can be provided only when there is a dental emergency, when an approved concurrent medical condition is present, or when prior authorization has been approved for a non-emergency dental service.

Dental rates were increased by 3.25% in FY 06-07, and remain between 33% and 50% of average commercial rates (as published by the American Dental Association). Because of low reimbursement rates, only a limited number of dentists provide services to adult Medicaid clients. Therefore, the Department recommends an appropriation of $3,500,000 to increase reimbursement rates for dental procedures by 7.38%. The Department

estimates that this will increase rates to between 35% and 54% of the American Dental Association mean rates. However, this is not an exact measure, as the mean rates are based on a survey of commercial providers who may vary their rates over time.

**Radiology Services**

Medically necessary physician ordered radiology services are benefits of the Colorado Medical Assistance Program. Radiology services include services using radiation (such as x-rays) or other imaging technologies (such as computed tomography, ultrasound and magnetic resonance imaging) to diagnose or treat disease. For the most part these are non-invasive services.

On average, the Department's current reimbursement rates for radiology procedures average approximately 23% of the equivalent Medicare rates. Radiology reimbursements were cut by 5% during FY 02-03 and have not been increased since that time. Because of low reimbursement rates, the Department remains concerned about client access to radiologists. The Department recommends an appropriation of $2,250,000 to increase radiology procedure codes by 17.7%.

**Prenatal Plus**

The focus of the Prenatal Plus Program is to improve birth outcomes by reducing the number of low birth weight infants born to eligible women. The program is administered in partnership with the Colorado Department of Public Health and Environment. Services are aimed at enhancing the medical component of prenatal care the woman receives. The goal is to improve the psychosocial and nutritional health status of the client, assist her in developing and maintaining healthy lifestyles during pregnancy and postpartum, discourage the use of tobacco, alcohol and illicit drugs and increase her ability to access critical medical and social services.

In conjunction with the Department of Public Health and Environment, a cost analysis of the program was completed in 2006 analyzing the program costs for calendar year 2005

for agencies providing PNP services. The analysis showed that on average the agencies are reimbursed 45% of the costs of the program. Overall the average cost per client in 2005 was $1,054 and Medicaid reimbursed at an average rate of $479 per client. Since 2004, five Prenatal Plus programs have been discontinued due to the financial hardship by the agency providing the program.

The Department recommends an appropriation of $500,000 to increase rates for the Prenatal Plus program by 51.5%. The Department estimates that at this level, rates would cover approximately 69% of provider costs.

Consequences if Not Funded:

If this Request is not funded, the Department risks having providers exit the program for lack of adequate reimbursement. Without adequate access to these services, clients are more likely to experience adverse health events which are more expensive to the Department.

Calculations for Request:

| **Summary of Request FY 08-09**<br>Matches Schedule 13 and Recommended Request | **Total Funds** | **General Fund** | **Health Care Expansion Fund** | **Federal Funds** |
|---|---|---|---|---|
| **Total of All Line Items** | **$17,091,875** | **$8,264,081** | **$281,858** | **$8,545,936** |
| **(2) Medical Services Premiums Incremental FY 07-08 Request (column 6)** | **$17,091,875** | **$8,264,081** | **$281,858** | **$8,545,936** |
| Increase to Inpatient Hospital | $4,679,688 | $2,260,347 | $79,497 | $2,339,844 |
| Increase to Evaluation and Management - Age Specific Codes | $1,514,747 | $731,642 | $25,732 | $757,373 |
| Increase to Evaluation and Management - Other | $1,750,000 | $845,272 | $29,728 | $875,000 |
| Increase to Medical Home Pilot Program | $222,255 | $107,352 | $3,776 | $111,127 |
| Increase to Substance Abuse | $750,000 | $362,259 | $12,741 | $375,000 |
| Increase to Radiology | $2,250,000 | $1,086,778 | $38,222 | $1,125,000 |
| Increase to Vision Benefits | $500,000 | $241,506 | $8,494 | $250,000 |
| Increase to Dental Services | $3,500,000 | $1,690,543 | $59,457 | $1,750,000 |
| Increase to Prenatal Plus | $500,000 | $250,000 | $0 | $250,000 |
| Increase to Managed Care Organizations | $1,425,185 | $688,382 | $24,211 | $712,592 |

| **Summary of Request FY 09-10** Matches Schedule 13 and Recommended Request | **Total Funds** | **General Fund** | **Health Care Expansion Fund** | **Federal Funds** |
|---|---|---|---|---|
| **Total of All Line Items** | **$17,091,875** | **$8,264,081** | **$281,858** | **$8,545,936** |
| **(2) Medical Services Premiums Incremental FY 07-08 Request (column 6)** | **$17,091,875** | **$8,264,081** | **$281,858** | **$8,545,936** |
| Increase to Inpatient Hospital | $4,679,688 | $2,260,347 | $79,497 | $2,339,844 |
| Increase to Evaluation and Management - Age Specific Codes | $1,514,747 | $731,642 | $25,732 | $757,373 |
| Increase to Evaluation and Management - Other | $1,750,000 | $845,272 | $29,728 | $875,000 |
| Increase to Medical Home Pilot Program | $222,255 | $107,352 | $3,776 | $111,127 |
| Increase to Substance Abuse | $750,000 | $362,259 | $12,741 | $375,000 |
| Increase to Radiology | $2,250,000 | $1,086,778 | $38,222 | $1,125,000 |
| Increase to Vision Benefits | $500,000 | $241,506 | $8,494 | $250,000 |
| Increase to Dental Services | $3,500,000 | $1,690,543 | $59,457 | $1,750,000 |
| Increase to Prenatal Plus | $500,000 | $250,000 | $0 | $250,000 |
| Increase to Managed Care Organizations | $1,425,185 | $688,382 | $24,211 | $712,592 |

| **Table 1** | | | |
|---|---|---|---|
| **Calculation of Impact to Inpatient Hospital** | | | |
| **Row** | **Item** | **Total** | **Notes** |
| A | FY 06-07 Expenditure for Inpatient Hospital | $304,687,402 | Exhibit N, page EN-1. |
| B | Estimated Increase in Caseload from FY 06-07 to FY 07-08 | 1.50% | Exhibit B, page EB-1. |
| C | Estimated FY 07-08 Expenditure | $309,257,713 | FY 07-08: Row A + (1 + Row B) |
| D | Estimated Caseload Increase from FY 07-08 to FY 08-09 | 0.88% | Exhibit B, page EB-1. |
| E | Estimated Base Year Expenditure (Without Rate Increases) | $311,979,181 | Row C * (1 + Row D) |
| F | Requested Rate Increase | 1.50% | See Narrative |
| G | Estimated FY 07-08 Expenditure at 90% of Medicare Rates | $316,658,869 | Row E * (1 + Row F) |
| **H** | **FY 08-09 Total Request** | **$4,679,688** | **Row G - Row E** |
| All Exhibits refer to Section E, Exhibits for Medical Services Premiums. | | | |

| **Table 2** | | | | |
|---|---|---|---|---|
| **Estimated Percentage Increase by Service Category (Fee-for-Service)** | | | | |
| Service Category | FY 08-09 Estimated Reimbursements(1) | Requested Increase | Estimated Reimbursements with Increase | Percentage Increase |
| Evaluation and Management - Age Specific Codes | $1,900,387 | $1,514,747 | $3,415,134 | 79.71% |
| Evaluation and Management - Other | $9,007,414 | $1,750,000 | $10,757,414 | 19.43% |
| Medical Home Pilot Program | $0 | $222,255 | $222,255 | 100.00% |
| Substance Abuse | $183,305 | $750,000 | $933,305 | 409.00% |
| Vision Benefits | $1,494,762 | $500,000 | $1,994,762 | 33.45% |
| Dental Services | $47,445,069 | $3,500,000 | $50,945,069 | 7.38% |
| Radiology | $12,705,840 | $2,250,000 | $14,955,840 | 17.71% |
| Prenatal Plus | $1,072,400 | $500,000 | $1,572,400 | 46.62% |
| **Total** | **$73,809,177** | **$10,987,002** | **$84,796,179** | **14.89%** |
| (1) Calculated using paid claims from the Department's Medicaid Management Information System. Estimated reimbursements only reflect portion of claims impacted by rate increases. | | | | |

**Table 3**
**Estimated Increase Including Managed Care Organizations**

| Service Category | Fee-for-Service | HMO | PACE | Total |
|---|---|---|---|---|
| Inpatient Hospital | $4,679,688 | $561,563 | $109,391 | $5,350,642 |
| Evaluation and Management - Age Specific Codes | $1,514,747 | $158,977 | $30,968 | $1,704,692 |
| Evaluation and Management - Other | $1,750,000 | $183,667 | $35,778 | $1,969,445 |
| Medical Home Pilot Program | $222,255 | $0 | $0 | $222,255 |
| Substance Abuse | $750,000 | $0 | $0 | $750,000 |
| Radiology | $2,250,000 | $236,143 | $46,000 | $2,532,143 |
| Vision Benefits | $500,000 | $52,476 | $10,222 | $562,698 |
| Dental Services | $3,500,000 | $0 | $0 | $3,500,000 |
| Prenatal Plus | $500,000 | $0 | $0 | $500,000 |
| **Total** | $15,666,690 | $1,192,826 | $232,359 | **$17,091,875** |

Definitions

HMO: Health Maintenance Organization
PACE: Program of All-Inclusive Care for the Elderly

Assumptions for Calculations:

For all calculations, the impact to the Health Care Expansion Fund is calculated based on the Department's FY 06-07 actual expenditure. Specifically, in FY 06-07, 3.40% of State expenditure was from the Health Care Expansion Fund. The Department holds that percentage constant and adjusts fund splits based on that percentage. Rate increases for services are applied without respect to eligibility category. When a client in an eligibility category which is funded from the Health Care Expansion Fund (such as Expansion Adults) utilizes a service which has received a rate increase, the additional expenditure must also come from the Health Care Expansion Fund.

In general, all estimated figures for FY 08-09 are based on historical expenditure and caseload trends. Actual experience will differ from the projection. Unforeseen increases in caseload or utilization could cause the Department to require an additional

appropriation in the future for these services. Any observable difference between the estimate and the actual experience will be adjusted in the Department's Budget Request for Medical Services Premiums in November 2008 and February 2009.

**Inpatient Hospital**

The Department has estimated the increase to inpatient hospitals based on FY 06-07 actual expenditure and projected caseload and utilization trends. This analysis is performed at the aggregate expenditure level, as an increase to the base rate of each hospital and does not affect the relative value of the claims submitted. In particular, this analysis assumes that the Department will not adjust the inpatient hospital payment methodology to match the new Medicare methodology effective October 1, 2007. In the event that the Department does update the payment methodology, a separate Budget Action will be submitted.

**Fee-For-Service Categories**

For evaluation and management procedures, medical homes, vision benefits, dental benefits, and radiology, calculations are performed on a procedure code basis. The Department calculated the estimate by analyzing claims at the procedure code level, inflating for increases in caseload and applying the rate increase. This methodology assumes that utilization rates will remain constant. Because of the size and complexity of the estimate, detailed calculations are not presented, although further information is available on request from the Department.

**Managed Care Impacts**

The Department has based impacts for managed care organizations, including both health maintenance organizations and the Program of All-Inclusive Care for the Elderly, on actual FY 06-07 experience. Although actual enrollment in these programs may differ from the FY 06-07 level, the aggregate impact for each category (e.g. inpatient hospital) will remain the same regardless of the distribution of enrollment. The Department will

adjust for any discrepancy between the actual experience and the estimate in its Budget Request for Medical Services Premiums in November 2008 and February 2009.

Estimates for managed care impacts are calculated by splitting total managed care expenditure by service category based on historic fee-for-service expenditure. Because of the size and complexity of the estimate, detailed calculations are not presented, although further information is available on request from the Department.

Impact on Other Government Agencies: None.

Cost Benefit Analysis: For this Request, a quantitative cost-benefit analysis is not applicable. Cost savings may not be realized in the near future but costs avoided over the long term may be considerable. The Department believes that there are significant benefits to increasing provider rates, including:

- Maintaining client access to primary care and emergency health care services
- Maintaining client access to specialty services, such as the Medicaid substance abuse benefit
- Increasing provider participation in the Medicaid program
- Preventing adverse health outcomes, which are generally more costly than primary care services

For these reasons, the Department believes that the short- and long-term benefits of increasing provider rates outweigh the costs.

Implementation Schedule: The new rates will be effective July 1, 2008

Statutory and Federal Authority: 25.5-4-104, C.R.S. (2007). Program of medical assistance - single state agency.
*(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance*

*with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.*

25.5-5-101, C.R.S. (2007). Mandatory provisions - eligible groups - repeal.
*(1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203.*

Performance Measures:

This Change Request affects the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs.
- Increase the number of children served through a dedicated medical home service delivery model.
- Improve access to and the quality of Medicaid health care as demonstrated through improvements in the Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.

The Department believes that maintaining an adequate provider network through fair and competitive rates will increase overall access to health care, thereby increasing customer satisfaction and quality of health outcomes. Additionally, the Department believes that the Medical Home pilot program will increase the number of children served in a medical home in FY 08-09 and beyond.